



SRF ID (RTPCR): 0707900531079

ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

INTRODUCTION:

This form is for collection centres / labs to enter details of the samples being tested for Covid-19. It is mandatory to fill this form for each and every sample being tested. It is essential that the collection centres / labs exercise caution to ensure that correct information is captured in the form.

INSTRUCTIONS:

- Inform the local / district / state health authorities, especially surveillance officer for further guidance
- Seek guidance on requirements for the clinical specimen collection and transport from nodal officer
- This form may be filled in and shared with the IDSP and forwarded to a lab where testing is planned
- Fields marked with asterisk(*) are mandatory to be filled

SECTION A – PATIENT DETAILS**A.1 TEST INITIATION DETAILS***Sample collected first time : Yes ☒ No ☐

If No, Patient ID :

A.2 PERSONAL DETAILS*Patient Name: **VIKRAM SINGH PANWAR**

Father's Name:

*Age: **39** Years*Gender: Male ☒ Female ☐ Others ☐*Occupation: **Other***Mobile Number: **9599271279***Mobile Number belongs to: Self ☒ Family ☐*Nationality: **India***Present patient address: **E 383***Downloaded Aarogya Setu App: Yes ☒ No ☐**GALI NO 7 WEST VINOD NAGAR**Pincode: **110092***District : **NEW DELHI***State : **DELHI**

(These fields to be filled for all patients including foreigners)

Aadhaar No. (For Indians):

* Passport No. (for Foreign Nationals):

A.3 SPECIMEN INFORMATION FROM REFERRING AGENCYSpecimen type Throat Swab ☒ Nasal Swab ☒ Bronchoalveolar lavage ☐ Endotracheal Aspirate ☐ Nasopharyngeal Swab ☐*Type of test **RT-PCR** ☒ **Rapid Antigen Test (RAT)** ☐*Collection date **29/01/2021***Sample ID(Label) **NDDIH9029012021**If, RT-PCR test, name of lab where sample is sent for testing **APLLTNND - Aarogya Pathcare LLP, Tilak Nagar, New Delhi**

* Mode of Transport used to visit testing facility

Symptomatic ☐ Asymptomatic ☒Contact of a lab confirmed case : Yes ☐ No ☒

Please Note - Hospital form is required for the patients visiting OPD, IPD and Emergency and Community form is required for patients under containment zone/ Non-containment area/ Point of entry/ Testing on demand

A.3.1 For Community*Not Applicable**

A.3.2 For Hospital*Cat 4: Testing on Demand** ☒

** Fields marked with asterisk are mandatory to be filled*

Please Note: Section B1 and B2 need to be filled for both Community and Hospital settings.

Section B3 needs to be filled only for Hospital settings

Section B- MEDICAL INFORMATION**B.1 CLINICAL SYMPTOMS AND SIGNS**

Cough	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	Other symptoms, please specify	
Date of onset of First Symptom :			

B.2 PRE-EXISTING MEDICAL CONDITIONS

Diabetes	<input type="checkbox"/>	Over weight/ Obesity	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Chronic lung disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Chronic Kidney disease	<input type="checkbox"/>	Any other please specify	

B.3 HOSPITALIZATION DETAILS

Hospitalized : Yes ☐ No ☒

Hospital State:

Hospital District:

Hospitalization Date:

Hospital Name:

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt (dd/mm/yy)	Sample accepted/Rejected	Date of testing (dd/mm/yy)	Test result (Positive/Negative)	Repeat Sample required (Yes/No)	Sign of the Authority(Lab in charge)